Participant and Reviewer Identification Data

Please be as thorough as possible in your answers.

1. PARTICIPANT INFORMATION
Fill in the name of the participant whose file is being reviewed. Include middle initial if available.

Last Name

First Name

Middle Initial

ID Number

2. COUNTY SUPPORT & SERVICE COORDINATOR CONTACT INFORMATION
Enter the name or if there are split roles, i.e. contract case management, enter the names of all the persons doing case management and their roles and functions.

Name 1 (Last, First, MI)

Role 1

Name 2 (Last, First, MI)

Role 2

Name 3 (Last, First, MI)

Role 3

3. COUNTY OF RESPONSIBILITY
Choose the name of the county of financial responsibility from the dropdown list. If one county has contracted with another to do the case management function, enter the name of the county that is taking financial responsibility for the participant.

-- None --

4. DATE RECORD REVIEW COMPLETED
Enter the date the CIS completed the review.

mm/dd/yyyy

5. REVIEWER INFORMATION
Enter CIS name and PROACT assigned number.

Last Name

First Name

PROACT Number

File Materials for Eligibility

Answer Key: Yes = This is an affirmative anwer to the question. No = This is a negative answer to the question. N/A = This means the question is not applicable.

6. Financial Eligibility: Is documentation present?

	YES	NO	N/A
DDES 919 (Cost Share Worksheet)	○	○	○
CARES Screen	○	○	○

7. Date of most recent completed form:

[ ] mm/dd/yyyy

8. Is the participant required to pay a cost share to maintain eligibility?

○ Yes
○ No

9. Is the participant financially eligible to continue to receive waiver services?

○ Yes
○ No

Level of Care Determination:

10. LOC Determination:

	YES	NO	N/A
A) Is there evidence that the Support Service Coordinator is registered and trained to use the LTCFS?	○	○	○
B) For CIP, has the Long Term Care Functional Screen been completed within the past 12 months?	○	○	○
C) After reviewing case notes and the current assessment, is the information on the Long Term Care Functional Screen accurate?	○	○	○
D) For BIW, has the DDE 2256 & 2256a been completed in the past 12 months?	○	○	○
E) Is the participant functionally eligible for the waiver program?	○	○	○

Individual Service Plan; Process and Content

11. Individual Service Plan (DDE 445); Process and Content

	YES	NO	N/A
A) Was the Individual Service Plan (DDE 445) updated within the past twelve months?	○	○	○
B) Was the Individual Service Plan (DDE 445) updated when there were changes?	○	○	○
C) Is there evidence that the Individual Service Plan (DDE 445) was reviewed annually, at six months or when changes occurred?	○	○	○
D) Is there evidence that the Individual Service Plan (DDE 445) was reviewed by the designated county staff with the participant and guardian?	○	○	○
E) Are all required fields on the DDE 445 filled in completely?	○	○	○
F) Do all services and costs listed on the DDE 445 match the services on the L-300?	○	○	○
G) Is there evidence that room and board is paid from a source other than the waiver?	○	○	○
H) Is there documentation on the DDE 445 that indicates how much the participant pays for room and board?	○	○	○
I) Is the personal allowance or monthly spending allocated listed on the DDE 445?	○	○	○
J) Are there any contributions by the participant for waiver-covered services in a substitute care setting?	○	○	○
K) Is the cost share, if any, documented on the DDE 445?	○	○	○

12. Is there documentation in the participant's file that indicates that the county has assessed the provider qualifications?

- ○ Yes
- ○ No

13. Do the qualified providers match the participant's needs?

- ○ Yes
- ○ No

14. Identify the entity managing the participant's funds

- ○ Participant
- ○ County Waiver Agency
- ○ Financial Management Services (HSRS 619) Provider
- ○ Other Waiver Service Provider
- ○ Guardian or Family Member

○ Other, please specify

15. Does the DDE 445 list any conflicts of interest?
(If "No" go to question 18)

○ Yes

○ No

16. If Yes to the previous question, is the strategy to remediate the conflict acceptable?

○ Yes

○ No (Explain below)

17. Were any conflicts of interest identified during the review of the ISP and the rest of the file that were not identified on the DDE 445?

○ Yes

○ No

18. Is the Individual Outcomes page of the DDE 445 complete and up to date?

○ Yes

○ No

19. Is there evidence in the file notes that shows the outcomes were developed with the consumer and/or others who may have some information to provide?

○ Yes

○ No

20. Is the ISP DDE445 complete and approved as part of the on-going service packet?

○ Yes

○ No

County Monthly Recertification & Related Info

21. Is there evidence that indicates the most recent county Monthly Recertification Assurance Report was completed?

- ○ Yes
- ○ No

22. Is the recertification approval letter from DD Services Section in the participant's file?

- ○ Yes
- ○ No

23. Is there documentation that HFS 94 Rights and Grievances Procedure information has been shared with the participant and/or guardian, if any, both in writing and verbally on an annual basis?

- ○ Yes
- ○ No

Waiver Variances Applied for and Approval

24. Is there documentation of a variance for institutional respite?

- ○ N/A
- ○ No
- ○ Yes (enter expiration date below)

25. Is there documentation of a variance asking for services on the grounds of an institution?

- ○ N/A
- ○ No
- ○ Yes (enter expiration date below)

Support and Service Coordination

26. Is there sufficient evidence that the number of required contacts have been met?

- Yes
- No

27. Is the narrative and assessment updated to reflect changes?

- Yes
- No

28. Do the case notes describe what is happening in the participant's life?

- Yes
- No

29. Is there evidence that the case notes are reflective of the service the participant is receiving?

- Yes
- No

30. Is there evidence that the Support and Service Coordinator uses an acceptable method to keep the assessment up to date?

- Yes
- No

31. Is there sufficient assessment information in the participant's file to determine that the service plan continues to assure the participant's health, safety and welfare?

- Yes
- No

Critical Incidents

32. In the last 12 months was there evidence of a Critical Incident?
If "No," skip the rest of this section and begin again at the Restrictive Measures section.

- ○ Yes
- ○ No

33. If a report is in the file, is there documentation that the report was sent to BLTS?

- ○ N/A
- ○ Yes
- ○ No

34. Did the reports contain sufficient information to indicate the situation was successfully resolved?

- ○ Yes
- ○ No (Explain below)

35. Were follow-up responses to the incident documented in the case notes?

- ○ Yes
- ○ No

36. Was the response to each Critical Incident resolved in a manner that assured health and safety needs were met?
If "No," a Corrective Action Plan is needed

- ○ Yes
- ○ No

Restrictive Measures

37. Are there any indications in the participant's record that Restrictive Measures are needed or being used?
If "No" skip the rest of this section

- ○ Yes
- ○ No

38. Is there a current Restrictive Measures Approval in place for each restrictive measure?

- ○ Yes
- ○ No (Explain below)

Survey Completion

39. Sign off to complete the review.
Choose one of the following:

- ○ Record met all requirements
- ○ Deficiencies found requiring corrective action (Enter date Corrective Action Plan due to CIS below: